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# Four priorities in international health financing to consider after the Paris Summit

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The recent Paris Summit «For a New Global Financial Pact» confirmed that international financing for development is a major concern for governments in the South and their external partners. Somewhat surprisingly, however, the issue of international financing for health remained off the agenda and sidelined from the debates. The aim of this note is therefore to contribute to reflection on international development financing from the specific perspectives of health. It examines four issues of particular importance to international financing in this sector. Firstly, it highlights the need for a massive increase in international health financing to reduce the gap that separates many developing countries from achieving Sustainable Development Goal 3 «Ensure good health for all, and promote well-being for all at all ages» by 2030.

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. . . /. . . Health aid plays a crucial role in health financing in low-income countries, where its share is on average greater than that of governments. A sharp increase in net public health aid flows will be essential, as will a strong mobilization of private flows which have remained modest until now in low income countries. The challenges ahead are considerable. The note explains how this justifies making improving the efficiency of healthcare spending a top priority for governments and their external partners. Not to do so would be to squander resources that will remain woefully inadequate. Numerous studies show that there is significant room for manoeuvre, while in most low-income countries and in many middle-income countries, other approaches to widening fiscal space and easing the financial constraints on healthcare remain limited. Furthermore, Covid 19 highlighted the low resilience of many countries' healthcare systems when it comes to coping with pandemics. This is hardly surprising, given the low level of the main indicators to be considered. It is therefore imperative to strengthen countries' capacity to prepare and respond to the inevitable future pandemics, which in the immediate term means giving a major boost to the intervention capacity of the new, drastically under-resourced Pandemic Fund. Finally, the note makes the case for governments and their external partners to make more extensive use of SWAp in the health sector. Not all contexts lend themselves to SWAp, but when the environment is conducive to their use - particularly the quality of Public Financial Management (PFM) - they offer many potential advantages for improving the effectiveness and efficiency of health aid.



## Introduction

International financing for development has been a major preoccupation of the governments of low- and middle-income countries (LMICs) and their external partners for the past three decades, as evidenced by the Paris, Accra, Busan and Addis Ababa conferences, among others, and, most recently, the Paris Summit «For a New Global Financial Pact» (June 22-23). Yet, somewhat curiously, the issue of international health financing has been sidelined from the agenda and debates. The aim of this note is to contribute to the debate in this field by focusing on four issues of particular importance to the international financing of the healthcare sector. The first section shows the crucial role played by aid in health financing, and why stepping up efforts to mobilize additional external funding is essential to achieving the health SDG. At the same time, however, it is just as essential to make improving the efficiency of healthcare spending a top priority for governments and their external partners (section 2). Covid 19 showed how vulnerable developing countries are to pandemics, as they are poorly prepared to cope with them. Section 3 outlines how developing an appropriate response capacity requires a major financial effort from the international community, particularly in terms of large-scale support for the recent and drastically underfunded Pandemic Fund. Section 4 shows why governments and donors should make more use of the health sector-wide approach (SWAp), as it can address a number of obstacles to improving the effectiveness of health aid.

## The need to increase international health financing to narrow the gap between countries and the health-related SDGs

***A sharp increase in health financing, but a volume of resources that is still far short of what is needed***

Since the beginning of the last decade, health financing has risen sharply in developing countries, including low-income countries (LICs), where it has increased from $88 PPP (purchasing power parity) per capita in 2010 to $110 in 2020

(WHO, 2022), an uplift of 25%. However, in many of these countries, these figures are barely equivalent to what would be needed to achieve a functioning first-level healthcare system[1] delivering quality services (Watkins et al., 2017). There is therefore a considerable funding gap with respect to Sustainable Development Goal 3 «Enable all people to live in good health, and promote well-being for all at all ages».

### *The crucial role of health aid in low-income countries*

The efforts made by local governments and their international partners during the Covid years 2020-2022 have led to a significant increase in per capita total health expenditure, both from governments and from health aid.

A recent World Bank study (Kurowski et al, 2023) analyzed the evolution of central government health spending in 16 LICs. On average, it rose by around 30% between 2019 and 2020 (19% in a WHO study of 24 LICs; WHO, 2022), but then contracted in 2021 and 2022, back to an amount fairly close to 2019 ($11.7 vs. $10.5). A comparable trend can be observed on average for middle-income countries and those eligible for IDA funding.

Health aid has always played a crucial role in the total health financing of LICs. It accounts for 30% in 2020, more than government (25%), although the latter's share has increased in 2020 from 20%-22% in the last decade. The essential role that health aid plays in LICs contrasts sharply with its 3% share in lower-middle-income countries. That said, out-of-pocket payments by users, although down slightly since 2010, remain the main source of healthcare funding in LICs, accounting in average for 40%, with widely-studied consequences for the non-seeking of healthcare and poverty.

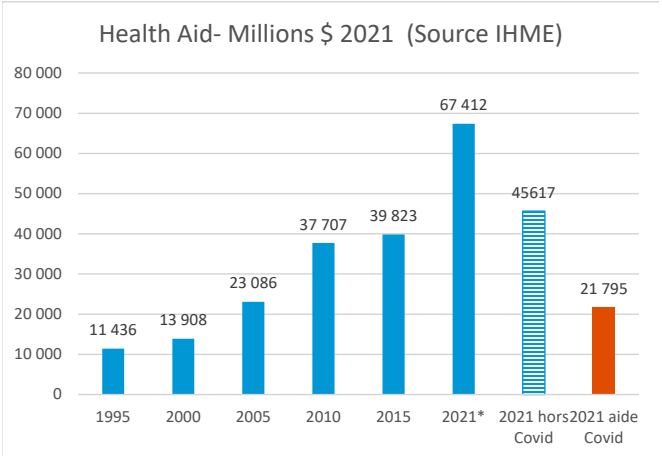
Between 2000 and 2021, health aid for all developing countries tripled, from $14 billion to $46 billion, excluding aid for Covid (Figure). Including Covid, this rise to $67 billion[2] (IHME, 2022). Between 2019 and 2020, the international contribution against Covid led to a 44% increase in health aid, a historically unprecedented leap, followed by a 9% increase between 2020 and 2021. Without the Covid support, it has stagnated (+1%) for the last two years[3], emerging however from the plateau phase of the middle of the last decade.

### *The need to increase public and private international health financing[4] to reduce a huge resource gap*

Various estimates have been made of the financing required to achieve the health SDG by 2030. The figures vary from one study to another, but all highlight the massive efforts required, particularly in LICs. For example, Stenberg et al. (2017) estimate in their «moderate» scenario that it would be necessary to mobilize an additional $70 (unadjusted for inflation) per person per year by 2030. Comparing the orders of magnitude found in the literature, as approximate as they may be, with the current levels of healthcare spending seen above shows the scale of the challenges to be met over the next few years in an environment that promises to be less than

1. Providing basic health care and playing a crucial role in the health SDG.

2. 2021 constant dollars.
3. IHME estimates, January 2023.
4. Total net flows (net debt transfers plus grants).



favorable. This is particularly the case for African LICs, which are faced with a need for macro-economic consolidation, debt servicing absorbing a growing share of public revenues, increased pressure from the climate crisis, and for some of them, growing political instability and insecurity. Against this backdrop, an increase in international funding for healthcare, mainly from ODA for LICs, is essential. But international public financing must also be mobilized to attract external private funding to health, which is virtually non-existent in LICs apart from large foundations and NGOs. This is an essential issue in development financing (Ferdi, 2023), and there is no reason in principle why the health sector should be an exception.

## Make efficiency improvements in healthcare spending a top priority for stakeholders in international financing and recipient countries

***For what reason?***

In short, improving efficiency means achieving more results (whatever they may be) with the same volume of resources, or producing the same results with fewer resources, without compromising the quality of services if non-health indicators are considered.

Part of the efforts being made to increase international health financing would be wasted if improving the efficiency of health spending did not in parallel become a top priority for governments and their external partners. There are five main reasons for this.

(i) In many LICs, the financing gap to reach the health SDG will remain considerable as we have seen, and improving efficiency is equivalent to increasing resources.

(ii) Prospects for enlarging the fiscal space from which health could benefit are poor. The capacity of governments to substantially increase their tax revenues remains weak in most of LICs (IMF, 2023). Debt levels are worrying in 19 out of 35 low-income African countries, and the burden of interest payments on external and domestic debt is going to increase on public finances. The adoption of debt service relief measures is being discussed in various fora, including the Common Framework for Debt Treatments, which enables official creditors of the G20 and Paris Club to adopt debt treatment measures for countries in difficulty. So far, however, coordination between the numerous creditors has proved tricky, and the process is proving slower than expected [5] (IMF, 2023). That said, if past experience is anything to guide us, cautious optimism is appropriate when it comes to estimating their impact on increasing sustainable public spending on health (Plant and Lee, 2022).

(iii) Health sector faces stiff competition with other sectors, such as education, agriculture and climate, particularly in recent years, which *de facto* limits the government's position to increase health's share of total public spending.

(iv) Numerous studies show that, in all countries, there is often considerable scope for improving the efficiency of health expenditure, not only without altering the quality of care, but also by making it better[6]. Broadly speaking, there are four main approaches to increasing the efficiency of health spending, and action needs to be taken on all of them: developing the use of cost-effectiveness (or extended cost-effectiveness) analyses to select priority interventions in healthcare policies, notably for the setting up of the universal health coverage benefit package; strengthening strategic purchasing of services,

5. But an agreement was reached in June under the Common Framework for Debt Treatments to renegotiate part of Zambia's debt, with China as a partner to the deal. It should be noted that in 2019, China adopted a debt sustainability analysis framework that is very similar in key respects to that used by the IMF and the World Bank, including by adopting certain elements, such as the CPIA scores. Mathonnat J. (2020) «La Chine, la dette et les motivations de l'aide chinoise à la santé en Afrique sub-saharienne: où est l'arbre et où est la forêt?», FERDI Policy brief B204 (updated: August 2020).
6. The same is true for high-income countries.

which is still little used in LMICs[7] ; improving the efficiency of healthcare facilities by first assessing it[8]; strengthening coordination between stakeholders. Last but not least, increasing international health financing - total net public and private flows - without ensuring that improving efficiency is a top priority for governments and their external partners, contributes to creating or perpetuating a moral hazard that can only be detrimental to achieving the health SDG.

(v) In other words, undertaking considerable efforts to increase international health financing without tackling the issue of improving efficiency is like turning up the heating or air conditioning in a house while leaving the windows half open. It would therefore be highly advisable for international donors to make improving the efficiency of health spending a «great cause», and to convince the governments of recipient countries that this is an imperative, and that appropriate initiatives and programs should be put in place, as has been the case, for example, for essential generic medicines and for maternal and child healthcare. But the focus should not be limited to the efficiency of public spending or facilities. It should also include that of private providers, who deliver a large and often majority share of first-level healthcare in low-income countries (Grepin, 2016).

### *Four key points for improving efficiency, in which international health financing must play a major role*

Today, it's fairly clear where the main efficiency problems lie. But the definition and implementation of operational strategies are critically dependent on local contexts, as there is no such thing as «one size fits all». We focus here to highlighting what we consider as four key points for improving efficiency, and in which the international health financing community must play an important role in initiating and supporting local governement action.

*Seting up «Regional Health System Efficiency Observatories»*. Their general objective would be to support governments wishing to establish national observatories, and to assist them in the rigorous analysis and monitoring of the efficiency elements in which they decide to engage, with the support of their external partners. The support of regional observatories would be part of a process of parangonnage (approaches, processes, methods, sharing of useful international experience) enabling national observatories to provide governments with a body of information essential to the rational regulation of healthcare provision. At the same time, governments, led by the Ministry of Health, but also local structures for thinking and knowledge (partner universities in particular) would benefit from enhanced analytical capabilities to better inform decision-making on health policies.

*Bolstering the production of robust baseline data*, which is lacking for steering efficiency improvements. Improving efficiency requires a substantial effort in terms of information and statistics, on which the Ministry of Health must be able to rely with trust. Two specific areas require attention here (over and above mortality and health status data shortcomings, the importance of which has been emphasized many times ; cf *inter alia* Fan, 2023 ; Garenne 2021): the first is the question of who benefits from public spending on healthcare, and the second is whether the Ministry of Health has the statistical information it needs to regulate the healthcare supply.

On the *first point*, one is surprised to note that today we do not have a good knowledge of who benefits from public health spending, as the issue is rather poorly documented. Specifi-

7. Chalkidou et al (2020) have shown, based on simulations of three approaches to reforming public procurement of healthcare products, that 50 of the poorest low- and middle-income countries could achieve savings of between $10 and $26 billion a year. These orders of magnitude are to be compared with the $46 billion in health aid (Covid aid excluded) for 2021.

8. Improving efficiency is one of Ferdi's main areas of research in health. Studies on the efficiency of district hospitals in several African countries show a wide dispersion of efficiency levels, resulting in a high potential margin of increase in healthcare production (very frequently in excess of 20%), if in each country the efficiency of all district hospitals were to approach that of the most efficient.

cally, there are few benefit incidence analyses available for showing who benefits from public health spending, by quintile or decile of well-being. It would be useful if such analyses could be systematically included in public expenditure reviews, and for their results to be better used in policy design.

With regard to the *second point*, all the studies carried out by Ferdi on the efficiency of healthcare facilities in Africa have highlighted that governments do not have all the reliable information they need to rationally manage healthcare provision, due to the shortcomings and dysfunctions of their statistical systems. The problems are diverse, and concern in particular key information that is intended to be collected on a routine basis (missing or erroneous data - including orders of magnitude, inadequate controls prior to data being entered into the health information system, etc.). Only reliable data make it possible to link resources, activities and results in order to assess the room for manoeuvre for improving efficiency.

Efforts have been made in all countries, but the situation remains worrying in many of them, most notably in LICs. This data issue occupies a low position in the de facto hierarchy of health ministry priorities. There are many reasons for this, including a lack of resources and the need to arbitrate in favor of more urgent, more visible priorities, or those more likely to mobilize external partners. It is therefore pointless to point out that this is an issue that is primarily the responsibility of governments, since it is clear that they will not be in a position to undertake the required financial trade-offs. Their external partners, here mainly multilateral, must therefore act on a significant scale on these issues to compensate for government shortcomings, the main argument being the strong negative national and international externalities that the weakness of health information systems entails for the strengthening of health systems, their resilience and the improvement of health, whether in terms of policy definition, strategy implementation or evaluation.

*Tackling the chaotic fragmentation of health aid.* Health aid is highly fragmented, and this fragmentation is increasing. The number of bilateral and multilateral donors providing public funding to the health sector and the population-reproductive health sub-sector rose sharply between 2010-14 and 2015-19: from 164 to 219 for bilateral donors and from 43 to 53 for multilaterals (World Bank, 2022)[9]. Fan (2023) quotes an African country in which there are over 70 donor-funded information systems, with innumerable duplications and a wide variety of approaches, most often in silos. Furthermore, while the pooling of resources in the healthcare sector has great potential for reducing the transaction costs induced by the fragmentation of aid, the share of pooled resources in total public funding remains very low (13%; World Bank, 2022). Effective donor coordination is once again essential, for reasons of effectiveness, efficiency and externalities. This imperative need for strategic coordination, all the more so in a global health perspective, would justify the leadership of multilateral organizations on these issues. One option would be a joint initiative between WHO (Division of Data, Analytics and Delivery for Impact) and the World Bank.

*Prioritizing approaches that contribute to enhancing the overall efficiency of healthcare systems*. This is the case, for example, of cost-benefit analyses to select the content of the priority healthcare package in the gradual implementation of universal health coverage, or of strategic purchasing approaches, etc.

But it should also be acknowledged that certain approaches which are useful by themselves, are inefficient at the systemic level, even though

9. But as Le Roy and Séverino (2023) note, the fragmentation of aid in general can in some cases have advantages for the recipient country. This is also true in the health sector, where it can increase the bargaining power of governments, as shown by the examples of Rwanda, South Africa and Mongolia, among others. However, the fragmentation of health aid also feeds a number of vested interests in recipient countries (multiplication of coordination and project management structures, burgeoning commissions, trainings, per diems; national and local political influence in the decision-making process and project management, etc.). The result is naturally an aggregation effect of players who have in common a reluctance to promote a reduction in the fragmentation of health aid (Spicer et al., 2020).

they are in favor with several public and private donors. This is the case, for example, with mutual health insurance schemes based on voluntary enrolment. Despite strong external support over the past two decades, the results are disapointing. They cover only a small proportion of the African population (less than 10%), and many cannot be sustained without external funding. They can also accentuate the fragmentation of health systems.

While they play an important role in ensuring access to healthcare for their beneficiaries, and as such should be encouraged in the absence of short-term alternatives, their position in the process of rolling out universal coverage should be reconsidered. Three points have to be kept in mind. Firstly, we know that they often have little impact on the poorest households (first quintile). Secondly, because of their small size and the often large number of actors involved (multiple donors including NGOs, elements of civil society,…), they constitute a fragmented kaleidoscope. Last but not least, universal health coverage needs to be thought with a systemic approach. In countries where the informal sector often accounts for 80% of employment, it is well worth bearing in mind that rapid progress towards universal health coverage cannot be based on a system designed around voluntary enrolment in fragmented insurance schemes to cover basic care, the role of voluntary insurance should be limited in such a context to providing complementary coverage. It was this consideration that led Rwanda to introduce compulsory enrolment in community health insurance schemes by law in 2007, as a response to the government's frustration with the slow take-up of voluntary schemes, which were in addition weakened by the small size of their pools and often undermined by adverse selection. Since then, compulsory enrolment has strongly increased health coverage[10].

10. It is around 80% in 2021.

## Financing an accelerated strengthening of countries' capacity to cope with pandemics

### *The current landscape*

Covid 19 demonstrated the great fragility and low resilience of many countries' healthcare systems when it comes to coping with a pandemic. This should come as no surprise. The Ebola epidemic had already revealed the profound vulnerability of healthcare systems in African countries hit by the virus. More generally, a study published in 2019 (Talisuna et al.) on the assessment of 40 African countries' application of International Health Regulations, which constitute the general framework for assessing global health security, showed an alarming situation. More than three-quarters of countries had no or only limited capacity for emergency preparedness, medical countermeasures, personnel deployment and service coordination. In terms of prevention, 80% scored one or two out of five. Despite some progress, the situation has not changed significantly. Strengthening states' preparedness and response capacities to future pandemics is a typical example of a global public good that justifies collective international action over and above what is the responsibility of national policies. For understandable reasons, funding for health shock preparedness has always been underfunded in developing countries; this is partly due to the multiple priorities which, particularly in LICs and lower-middle-income countries, compete within the health sector for globally insufficient budgetary allocations, health itself being in competition with other sectors.

### *Strengthen the intervention capacity of the drastically under-resourced Pandemic Fund*

The creation in September 2022 of a Pandemic Fund is a first step that must be welcomed

unreservedly. In the end, the Fund was housed at the World Bank, which is a wise choice given the alternatives envisaged. One of the advantages of this choice is that it greatly limits the risk of the Fund's interventions being disease-oriented, whereas the ones required in terms of pandemic preparedness and response are mainly «horizontal» in nature; that said, with the diagonalization of vertical programs, the horizontality versus verticality dichotomy has lost some of its acuity (Mathonnat and Audibert, 2016).

In our view, the Fund faces three major challenges: insufficient resources, determining recipient country-specific potential envelopes, and the nature of expenditure eligible for funding.

*Shortage of resources.* To date (June 2023), the Fund has mobilized $1.6 billion (commitments), while it has received 650 expressions of interest with funding requests of over $7 billion, i.e. some 24 times the amount available ($300 million) under the first call for proposals[11]. Estimates of the funding required for an effective pandemic preparedness and response system have been made by several sources. The orders of magnitude vary considerably for methodological reasons and because of the scope of activities included in the estimates. For example, the World Bank and WHO recently estimated needs at $31.1 billion a year, including $10.5 billion from donors. A study by McKinsey in 2021 puts the figure at 85 to 130 billion dollars over two years, followed by 20 to 50 billion annually until 2030 (Shahid and Yamey, 2023; see also Micah et al., 2023). It should be remembered that health aid excluding Covid in 2021 is estimated at $46 billion, and at $67 billion including Covid. Whatever the scenario, and noting as the Pandemic Fund's Governance Framework makes clear, that one of the key objectives of the Fund is to use its resources to leverage additional investments for pandemic preparedness and response from recipient governments and the private sector, increasing funding for the Fund must be a high rank priority for international health financing, given the importance of global health issues. This challenge of insufficient funding, crucial and underlined by several observers, must not, however, cause us to lose sight of the importance of the other two: the criteria for determining country-specific potential envelopes and the nature of eligible expenditures.

*Determining country-specific potential envelopes.* A working group has been set up but has yet to deliver its conclusions. Eligible countries are those that are eligible to receive funding from the IBRD and/or the IDA[12]. In light of current debates on aid allocation criteria, it would be advisable to incorporate a multidimensional vulnerability criterion into the calculation of potential country envelopes (Guillaumont, 2023). The approach should also take into account the needs of individual countries on the one hand, and the impact of interventions at both country and global/regional levels on the other to take positive externalities into consideration. Consideration should also be given to whether or not a country is a «weak link»[13] in terms of global pandemic preparedness targets, taking into account both the country's potential role in a future pandemic and the constraints it will face in coping with its responsibilities. The question also arises as to whether regional organizations (which ones?) should have the possibility of adjusting the formula or the approach to suit certain specificities. Here we find elements which, in some respects, echo the debates on the allocation of SDRs.

*Eligible expenditures*. Countries' capacity-building to cope with pandemics will require capital as well as recurrent expenditures (human resources, operations and maintenance). Whatever the share of the latter in the total, it is clear that they will play a major role in the effective-

11. https://www.worldbank.org/en/programs/financial-intermediary-fund-for-pandemic-prevention-preparedness-and-response-ppr-fif/brief/demand-for-funding-from-pandemic-fund-exceeds-expectations-with-requests-totaling-over-7-billion.

12. Financial Intermediary Fund For Pandemic Prevention, Preparedness and Response Operations Manual, World Bank, 2023.

13. The expression «weak link» is from Severino and Guillaumont (2023).

ness of the programs financed by the Pandemic Funds. Leaving it to the government alone would be an adventurous approach, and would weaken the whole structure, particularly in LICs where health spending is already largely insufficient, as we have seen. It therefore appears essential for the Fund to finance a portion of current and recurrent expenditures, which would be consistent with the Fund's Guiding Principles on Co-financing, Co-investment, and Country Ownership document.

## Making the case for a more widespread use of SWAp in the health sector

In the context of the current debate on international financing for development, and considering the specific issue of health financing, it is worth highlighting the potential contributions of a health SWAp to the achievement of the health SDG.

A Sector-Wide Approach (SWAp) is a process of in-depth consultation and collaboration between the government and its main external partners to improve the effectiveness of aid (to health or another sector) in line with the Paris, Accra and Busan declarations, the government being in the driver's seat. The SWAp approach, or a mechanism of this type, does not necessarily involve pooling the resources of all the donors involved in the scheme. It is, by construction, a very suitable instrument for strengthening coordination between donors and reducing the effects of health aid fragmentation, for at least partially neutralizing fungibility or for organizing it, for improving aid alignment and government ownership, and thus increasing the efficiency and effectiveness of health aid.

It is also a framework for exchanges that helps to limit unrealistic estimates of domestic and external healthcare funding, which lead to trade-offs and readjustments during the course of the year, undermining the coherence of healthcare policies.

A SWAp also fosters open dialogue on conditionalities to prevent them from mushrooming across all health aid programs. It should be remembered here that, contrary to popular opinion in some circles, the Minister of Health may request conditionalities whether on instruments, processes, results or impacts for a variety of reasons (with regard to a part of the administration being hostile to measures of which the Minister is convinced of the relevance; with regard to the Ministry of Finance to support its request for a larger budget, etc.). Conditionalities can thus be the expression of a shared vision between the Ministry of Health and its external partners. A SWAp is also likely to encourage the implementation of an approach focusing health aid on marginal investments («marginal aid» approach proposed by Drake, Regan and Baker, 2023[14]).

But implementing a health SWAp is complex, not necessarily relevant to the local context, highly dependent on the quality of Public Financial Management, it could be resisted by global funds and certain multilateral or bilateral donors, depending on the country, and the results are not homogeneous, whatever the analytical perspective adopted. However, the results are generally positive to varying degrees with respect to the objectives that have been sought (cf. Peters et al., 2013; Sweeney et al., 2021; Wood et al., 2021).

Finally, to conclude this plea, a health SWAp has two more general interests. Firstly, by its very nature, it offers a privileged ground to address possible reorientations of the government's health policy, and to facilitate the consideration of common goods with their thorny problems. Secondly, it can provide an intermediary approach between earmarked aid channelled through earmarked or extra-budgetary accounts[15], on the one hand, and global budget

14. « (…) Domesting financing would support the highest priority services and aid should be used to support the next-most-cost-effective or next highest priority services » (p.9).
15. Extra-budgetary accounts proliferated during the Covid 19 crisis, with varying effects. In some countries, for example, they helped reallocate resources within the national budget to meet the needs created by the pandemic, but in countries with fragile PFM, they were often associated with inefficiencies and inappropriate uses (Hsu et al. 2022).

support, on the other, in countries where fiduciary risks, fungibility, a fragile Public Financial Management framework and the exposure of aid to high levels of corruption would make global budget support adventurous.

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